authority rent officers consider to be reasonable or make up the shortfall themselves.

Given this background local authorities have not welcomed the proposed changes, seeing them as administratively cumbersome and detrimental to a vulnerable section of society.[6] The Faculty of Public Health Medicine has argued that the proposed legislation will "increase disruption of social networks necessary for relieving social isolation; increase stress within the family, increasing risks of domestic violence, child abuse, maternal depression and child behavioural disturbance; decrease access to primary care and community health services and decrease continuity of care in the community."[4]

May medicalise housing needs

The new legislation has some potential merits. It may allow closer integration of social housing with community care policy, the lack of which is a major problem of the current system.[4 7 8] It may also allow more efficient allocation of scarce social housing to those with medical conditions caused or aggravated by housing conditions. This outcome, however, rests on the assumption that it is possible to ascribe ill health to specific housing conditions and make some sort of order of priority among them.[9] Though the current system for medical priority for rehousing may be amenable to improvement,[10] a more likely result is an inappropriate medicalisation of housing need. A second assumption is that the new restricted provision will not itself adversely affect the health of those both given and excluded from assistance. The current shortage of permanent housing will mean that both eligible and ineligible homeless households are likely to spend even longer than at present in temporary accommodation. The mental stress, social dislocation, and poor conditions associated with such accommodation are not conducive to health.[4 11 12] The prevalence of poor housing is highest in the private rented sector,[12] yet this sector is expected to play a more prominent part in future.

In trying to make sense of these changes it is impossible to separate their likely effects from an undeclared notion of "eligible" and "less eligible" poverty.[13] Allocating state help with housing on a basis other than need is inappropriate for a resource which is a prerequisite to health.[4 11 12] The solution to homelessness in all its forms is to build more affordable homes and do this within a policy which explicitly recognises that homelessness is not acceptable or healthy in a civilised society.[4 12]

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Near patient testing in primary care

Offers better patient management but needs proper evaluation and quality control

Near patient or point of care testing has been documented at least since Thomas Willis (1621-1675) wrote of tasting urine to test for glycosuria. Today, every doctor uses dry reagent laboratory sticks for simple urine analysis or blood sugar estimation, both in clinics or offices and in patients' homes. In the United States near patient testing now comprises 20% of all testing,[1] and the past decade has seen increasing interest in the use of dedicated single test devices or desk top chemistry analysers among doctors in Europe, particularly in Britain,[2 3] the Netherlands,[4] and Scandinavia.[5] In all countries it is in primary care that the true potential for near patient testing will be realised.

Near patient testing could improve the accuracy of clinical decision making and the reliability of monitoring chronic diseases, assisted if necessary by expert decision support.[6] Primary care physicians are under multiple pressures to extend and improve their performance in these critical areas. These pressures include patients' increasing intolerance of late diagnosis, growing requirements to ration access to specialist care, sicker patients in the community because of earlier discharge from hospital, and the ever greater demands upon general practitioners to manage the surveillance of chronic diseases. However, if primary care physicians are to manage more patients more reliably and at least as safely, they will need accurate and efficient tools to assist their decisions (in addition to extra facilities and staff). Near patient testing will contribute to the wider use of appropriate investigation in primary care.

As with new drugs, the efficacy and safety of new diagnostic technologies must be demonstrated both in laboratory and practice settings, including clinical and economic comparisons of different technologies. One major problem is deciding who should fund such research. The most likely sources of funding in Britain will be the NHS central research and development health technology programme (which recently commissioned a systematic review on this subject) and the Medical Research Council through the Realising our Potential Awards (RoPAs) scheme.

Facilities for near patient testing will not be needed for every diagnostic or monitoring procedure in primary care. Electronic links enable rapid transmission of results from a hospital laboratory to a doctor's desk. In Britain this facility will be further enhanced with the advent of the new practice computer systems, which should enable results to be filed electronically and remotely in patients' records, thus reducing the costs and errors of transcription. However, unlike near patient testing, rapid electronic links will not enable clinicians to use test results in immediate management decisions.

The list of near patient tests that are potentially relevant to making urgent clinical decisions is substantial: tests for antibodies to *Helicobacter pylori*,[7] C reactive protein,[8] and cardiac troponin T[9 10] are already available, and many tests—such as for glycated proteins and for numerous drugs—are under development. An immediate result from a near patient test for C reactive protein might enable a doctor to avoid unnecessary prescribing of an antibiotic (by distinguishing between viral and bacterial infection) or help in the differential diagnosis of acute abdominal pain.[11] Near patient testing may also encourage doctors to be more discriminating in their choice of investigations, since the trend is towards developing devices that perform single rather than multiple tests.

In monitoring disease, near patient testing promises greater convenience to patients,[12] improved therapeutic control (if results are presented during the consultation),[13] and reduced overall health costs.[14] However, the full potential of near patient testing can be exploited only by finding the clinical niches where its use would be most likely to influence practice beneficially[14] and then finding mechanisms to enable its wider dissemination. This would go beyond the regular problems of implementing research findings, since for most general practices in Britain no method exists for funding such diagnostic testing.

No discussion on near patient testing can omit the importance of external quality assurance.[15] This priority might be best met by a coherent policy to develop near patient testing in primary care in collaboration with hospital clinical chemists. Equipment provided by specialists and used by general practice staff who have undergone laboratory training, combined with external quality assurance from central laboratories, might prove the most durable model.

In many situations primary care physicians will continue to use the powerful diagnostic tool of waiting and seeing.[16] However, the incremental use of fully evaluated near patient testing could help primary care to take its next logical evolutionary leap, to subsume the remaining functions of the hospital general physician within community settings.

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Impaired glucose tolerance

Detection and follow up should aim to reduce excess morbidity and mortality

Impaired glucose tolerance is defined as a fasting plasma glucose concentration of less than 7·8 mmol/l and between 7·8 and 11·1 mmol/l two hours after a 75 g oral glucose load. This definition was first established in 1980 by the World Health Organisation, replacing terms such as "borderline" or "chemical" diabetes.[1] It is based on long term prospective studies which conclude that individuals with lesser degrees of glucose intolerance are not at risk of microvascular complications such as retinopathy.[2] The advent of health promotion clinics and screening programmes is likely to mean higher rates of detection. However, the clinical significance of impaired glucose tolerance remains unclear.[3] Should people who are found to have impaired glucose tolerance be followed up, and what treatment, if any, should they receive?

Impaired glucose tolerance is common; it affects about 11% of people aged 20-74 years in the United States and 17% of those aged 40-65 years in Britain.[4 5] The pathogenesis is controversial, particularly the question of whether it is insulin resistance or insulin deficiency that predominates. (This may have implications for treatment since potential therapeutic agents have quite different mechanisms of action: sulphonylureas act by increasing insulin secretion, with some reports that they restore the early insulin release from pancreatic beta cells (the first phase insulin response); whereas newer agents such as the thiazolidinedione derivatives act by reducing insulin resistance.) Some studies have shown that people with impaired glucose tolerance have evidence of insulin resistance and hyperinsulinaemia.[6] However, the first phase insulin response, thought to be a critical factor in determining overall glucose tolerance, has been shown to be reduced in these people, showing that the development of impaired glucose tolerance requires both insulin resistance and impaired insulin secretion.[7 8] O'Rahilly *et al* showed that the normal pattern of pulsatile insulin secretion was lost in people with impaired glucose tolerance, and there may be qualitative as well as quantitative abnormalities of insulin secretion.[9]

People with impaired glucose tolerance have increased mortality from cardiovascular disease: the Whitehall study found that impaired glucose tolerance doubled the risk of death from coronary artery disease among middle aged male civil servants.[10] This has traditionally been ascribed to factors associated with glucose intolerance that exacerbate the atherogenic process. However, it has not been possible to explain the association between impaired glucose tolerance and cardiovascular disease by generally accepted risk factors such as diastolic hypertension, hypercholesterolaemia, or cigarette smoking; and epidemiological studies have found no association between coronary artery disease and either blood glucose concentration or duration of diabetes.[11 12] Reports that lipoprotein(a) concentrations may be increased in people with impaired glucose tolerance have limited implications for